CARE International in Tanzania

Third Annual Report of the Community-Based Reproductive Health Project

Kwimba and Missungwi Districts, Mwanza Region

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List of Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency syndrome
AMREF	American Medical and Research Foundation
BF	Breastfeeding
CBD	Community-based Distribution
CBRHP	Community-based Reproductive Health Project
CDC	Centers for Disease Control and Prevention
CSPD	Child Survival, Protection, and Detection Program (Gov't of Tanzania)
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DMO	District Medical Officer
EDP	Essential Drug Programme
EOC	Emergency Obstetric Care
HESAWA	Health Sanitation and Water Programme
HIV	Human Immunodeficiency Virus
FP	Family Planning
IEC	Information, Education, and Communication
IUD	Inter Uterine Devise
KPC	Knowledge, Practice and Coverage
LAM	Lactational Ammenorea
MCH	Maternal and Child Health
MOH	Ministry of Health
MTUHA	Ministry of Health Information and Statistics System
PHC	Primary Health Care
PPC	Post-Partum Counseling
PVO	Private Voluntary Organizations
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendants
TOT	Training of Trainers
TT	Tetanus Toxoid
UMATI	National Family Planning Association
UNICEF	United Nation Children's Emergency Fund
VHW	Village Health Worker
WDC	Ward Development Committee
WHO	World Health Organization
WRA	Women of Reproductive Age

1 Introduction

The overall purpose of CARE International in Tanzania's Community-Based Reproductive Health Project (CBRHP) is to reduce maternal and neonatal mortality through improved reproductive health services and practices in Kwimba and Missungwi Districts of the Mwanza Region. The first phase of this project runs from 1996 – 2000 with the financial support of USAID BHR/PVC PVO Child Survival Grant Program, CARE International and the Woodruff and Turner Foundations.

The project reaches more than half of a million people in 188 communities in nine rural divisions of the two districts. This target population includes 150,000 women of reproductive age who carry approximately 30,000 pregnancies every year. CBRHP has assisted the MOH in strengthening the quality of care at 66 health facilities in the two districts.

Four intermediate goals for population-based change drive the project efforts to increase:

1) utilization of supervised maternal health services;
2) appropriate utilization of emergency obstetric care services;
3) voluntary utilization of family planning; and
4) utilization of quality sexually transmitted infections services and prevention methods.

CBRHP collaborates with the Ministry of Health, community leaders, health volunteers, traditional birth attendants and healers, and health facility personnel to achieve these objectives. Key activities include through household birth planning, community emergency transportation planning, family planning promotion, STD control and prevention, upgrading maternal and neonatal services at health facilities and expanding supervised services to communities.

2 Progress by Objectives

In general, the project is making good and steady progress towards achievement of its objectives. The table below summarizes the extent to which the original project objectives presented in the detailed implementation plan are on target for achievement. However, it is to be noted that following a technical review of the project in March 1999, an improved, hierarchical set of objectives and indicators was established to better guide project implementation towards its goal of reducing mortality. This revised logical framework is presented under section 4.

	Objective	On Target	Comments
	Technical		
1	Increase percentage of women receiving 2 prenatal consultations from 55% to 75%	Yes	Due in part to the efforts of VHWs to support and advise all pregnant women, the majority of them attend 2 or more antenatal care consultations in the project area.
2	Number of villages that have functioning referral system will increase from 0 to 100	Yes	Although collaboration with CDC reinforces the referral system, this objective is poorly defined and the objective regarding transportation systems covers the intent of having referral capability in place.
3	Percentage of women whose last delivery was attended by trained TBA or health personnel will increase from 52% to 65%	Yes	This may be ambitious due to the high informal costs, but people recognize the benefit if the cost barrier can be overcome
4	Percentage of mothers who receive iron folate tablets will increase from 48% to 75%	Yes	MOH policy is to provide iron throughout pregnancy, but supplies are inadequate. At the moment, they send women home with 14 pills at a time from pre-natal care
5	Percentage of mothers who receive 2 or more TT will increase from 53% to 75%	Yes	VHWs informing pregnant women of their rights for TT protection and iron folate. When health facilities not providing this to antenatal clients, this is reported by the VHW to the DHMT and CARE.
6	Number of villages with emergency transport system will increase from 0 to 50	Yes	This is very ambitious due to the time it takes to truly get communities organized and the high cost of the solutions, but the project is putting a lot of effort in this direction. To date 32 communities have developed concrete transport action plans.
7	Health centers able to provide basic EOC will increase from 0 to 4.	Yes	TOT for EOC established and training for key staff from 5 health centers conducted. Availability of essential drugs, supplies and equipment continues to be a major barrier.
8	The percentage of mothers who can identify at least 2 danger signs of pregnancy will increase 40%.	Yes	Every pregnant woman receives birth-planning assistance by the VHWs. These visits concentrate on delivering messages about danger signs and appropriate actions. A population-based monitoring survey is underway.
9	The percentage of women who receive presumptive malaria treatment during pregnancy will increase from 0 to 25%	No	Chloroquine has recently been replaced with Fansidar as the front-line anti-malarial given high levels of chloroquine resistance per MOH policy. It will take up to 18 months to distribute Fansidar and train providers in treatment regime. Presumptive treatment of primigravidae and second pregnancy women will be reviewed with the MOH for inclusion in prenatal care protocols and included in prenatal care package.
10	Increase knowledge of the main modes of transmission of HIV/AIDS and STIs from 60 to 75%.	Yes	VHWs providing both group and individual IEC on modes of transmission of HIV and STIs. A population-based monitoring survey is underway to assess extent of knowledge

	Objective	On Target	Comments
			to-date.
11	Percentage of the population who can recognize at least two signs or symptoms of STIs will increase from 11% to 20%.	Yes	VHWs providing both group and individual IEC on signs and symptoms of STIs. A population-based monitoring survey is underway to assess extent of knowledge to-date.
12	The number of health facilities that have trained personnel to detect, counsel and refer STI cases will increase from 19 to 40.	Yes	Currently 24 health facilities have staff trained in syndromic management. CBRHP plans to train 16 in February 2000 following the completion of a cycle of transfers in the management and counseling of STI cases.
13	Proportion of mothers with children under 24 months who do not want another child in the next two years and are using a modern FP method will increase from 11% to 20%.	No	The target is ambitious given local attitudes about reproduction. This may be achieved in the initial 100 villages, but not in the newer ones. There is some evidence that post-partum family planning counseling is resulting in increased referrals for family planning service.
14	Percentage of mothers who are given a postnatal FP consultation will increase from 23% to 80%.	No	This may be possible in the initial 100 villages, but not in the newer ones. The project will be including BF counseling and discussion of LAM for PPC as part of dispensary training. The target is ambitious.
15	Number of health facilities with trained personnel providing comprehensive FP services will increase from 4 to 15.	No	There is very little demand for IUDs compared to basic family planning services. Resources should be used to strengthen basic services.
16	Number of health facilities with trained personnel providing basic FP services will increase from 23 to 40.	Yes	All health facilities are currently providing services and are targeted for increased supervision and training updates
	SUSTAINABILITY		
17	Facilities upgraded and covering both basic and comprehensive services	No	Training conducted and needs assessment completed; however, serious lack of drugs and supply is a major barrier to accomplishing this objective
18	Critical drugs and commodities are available 90% of time	No	No, beyond control of CARE as supplies come in sealed EDP kits. Communities report frequent essential drug outages at health facilities.
19	In-service training and supervision are functioning and monitored	Yes	DHMT constraints in budget for fuel for supervision
20	Communities select and support VHWs/CBDs	Yes	More than 400 community health volunteers in place in 118 villages. There are some problems with retention that are discussed in the next section of the report.
21	Cost recovery incentives are established	Yes	VHWs and TBAs sell drugs and supplies at 105% of cost
22	VHW/CBD replacement program operational	Yes	Orienting new VHWs in areas with dropouts and conducting periodic refresher training for all VHWs. VHW dropout is high.
23	Routine meetings with VHWs/CBDs and	Yes	Some communities with weak leadership

	Objective	On Target	Comments
	community leadership conducted		are doing this less than others
24	Communities establish organized groups and volunteers to develop a logistics, storage and supply system for essential drugs and FP commodities	Yes	Monitoring needs to be strengthened. Working with DHMTs on formal re-supply mechanism.

3 Constraints and Problem Solving Actions

During this year, the project faced several challenges and focused efforts on understanding and resolving them. CARE has taken a proactive approach and in collaboration with its MOH counterparts has sought to understand causes of the problem(s) and to develop and implement appropriate actions for their resolution.

The following are eight key constraints and progress in resolution to date:

⇨ **Point 1: Upgrading Health Centers to WHO Basic Emergency Obstetric Care (EOC) Standards.** While the project has taken the important steps of assessing health services, taking inventory of equipment and supplies, and training health center personnel in EOC, the continued lack of essential drugs, supplies and equipment continues at the five strategically located health centers remains a critical barrier to improved services. While skills of providers have been improved, the lack of essential materials to facilitate quality care remains a problem.

In most cases, the facilities have no stock of intravenous fluids for parenteral antibiotics and oxytocics, oxytocic drugs, blood pressure cuffs, and an insufficient supply of maternal cards with partograms. CBRHP is working closely with the District Medical Officers and UNICEF to promote the establishment and maintenance of adequate levels of supplies required to save lives during obstetric complications. CARE continues to seek further donor support for the MOH to upgrade services and provide technical support on cost sharing strategies.

CARE is currently working with the Reproductive Health Division of the Centers for Disease Control and Prevention (CDC) and the WHO Collaborative Center for Perinatal Health to continue to improve the quality of EOC services at health facilities in the area and to develop a perinatal health care surveillance system in two of the divisions.

⇨ **Point 2: Cultural acceptance of birth planning.** Planning for delivery is a challenging concept to promote due to the Sukuma's strong attitudes and beliefs about the importance of keeping pregnancy a secret. Underlying reasons for hiding the pregnancy include fear that any preparations for the newborn may result in a curse, jealousy and ill wishes by other members of the society.

Despite these barriers, CBRHP has found that women are willing to discuss birth planning openly among other pregnant women. The project has been successful engaging women in birth preparedness discussions during health education sessions at

MCH clinics. As the vast majority of women attend at least two prenatal visits during each pregnancy, this may be an appropriate approach to birth planning given cultural taboos. CBRHP is also working with community leaders to test approaches to involve other household decision-makers in birth preparedness. Birth planning guidelines for VHWs and TBAs have been developed to assist volunteer health promoters to utilize multiple social channels to reach household decision-makers.

⇨ **Point 3: Re-supply of First Aid Kits.** To date, no formal re-supply mechanism exists for VHWs first aid kits and TBA safe delivery kits. However, VHWs and TBAs have found their own channels for re-supply including working with pharmacists or business people and/or traveling to Mwanza themselves to restock. There is evidence that many VHWs and TBAs have been able to refill chloroquine, aspirin, condoms, iron folate, and gloves.

While the current system is functional, CBRHP aims to strengthen the supply of select essential drugs and supplies for VHWs with the Ministry of Health. As capitalization is underway at both Ngudu Hospital and Missungwi Health Center, CARE and the District Medical Officers are working together to establish a revolving supply of pharmaceuticals for VHWs and TBAs. It is believed that this arrangement will lower costs to community members and strengthen government oversight of the contents of the first aid kits.

⇨ **Point 4: Village Health Workers Activity Levels.** An increasing number of VHWs have been gradually reducing their activity levels due to poor/non-existent incentives and lack of community support. This is an alarming trend given that VHWs were trained just over one year ago. CBRHP and the MOH are working from several angles in attempt to reverse this negative trend. Strategies include: 1) advocacy for incentives package for community leaders to motivate volunteers for good work and increase supervision, 2) sensitization of community members to role of VHWs and TBAs, 3) focus group discussions with VHWs, 4) increased community-level supervision by CARE staff, and 5) re-selection of health volunteers under some circumstances.

Incentives Legislation for Village Health Workers: In early January this year, Regional and District Health Management Team members, CARE, and District Counselors prepared a proposal for consideration of the full District Councils in Kwimba and Missungwi regarding VHW incentives. The group proposed legislation that each village would make a token maximum payment of 10,000 TSh (approximately US$15) each month for all village health workers who are active. These funds are to be administered by the Ward Development Committee which is comprised of all village chairpersons and village executive officers in addition to the Ward Executive Officer and Counselor. By the end of March, the full District Council of Missungwi passed the legislation and the Social Services Committee in Kwimba approved the proposal for presentation to the full District Council in May this year. To date, village-level implementation of this legislation is sporadic and monitored by the MOH and CBRHP.

⇨ **Point 5: Project staff turnover.** Two critical management positions experienced turn over during the year, the Project Manager and Office Manager. This has resulted in increased operating costs for transfer and moving costs and some delays in regular project implementation and direction. These changes have not significantly affected the

overall project management and project guided by findings and recommendations from midterm evaluation.

⇨ **Point 6: Emergency food distribution:** The southern half of the project area was devastated by an acute food shortage from April – June 1999. During this time, project activities were hampered and attention was diverted as community members were too busy seeking a means for finding their next meal to participate in project activities. Given this emergency situation, the project and the World Food Programme collaborated to distribute six to eight week rations of powdered white maize to vulnerable households in affected villages in the project area during the month of June 1999. This had a slight impact on project activities during the month of distribution.

⇨ **Point 7: Quality of care.** It is clear that the poor quality of care at health facilities dampens efforts to build demand for services. The District Health Management Team and Field officers are working with government health facilities to establish a regular process for quality review, problem identification, and problem solving. See recommendation #13 on page 18 for specific work in this area.

⇨ **Point 8: Partnership and coverage of remaining divisions.** CBRHP is working with all health facilities from hospitals to dispensaries in all nine divisions of the project area. Through these efforts, the project is improving access to quality reproductive health services to the entire beneficiary population. Over the past two years, the project has successfully started activities with communities in six divisions of Ibindo, Mbarika, Missungwi, Ngudu, Usagara, and more recently Nyamilama divisions.

Given partner organizations complementary presence in the three remaining divisions of Inonelwa, Mwamashimba, and Ngula and the low levels of funding remaining for project activities, CBRHP works with its partners to expand its community component into these areas. These organizations include the Catholic Archdiocese in Ngula, UNICEF in Inonelwa, and Hesawa and UNICEF in Mwamshimba. Specifically, CBRHP will provide short reproductive health updates for partners' community volunteers, share tools and messages, and conduct training at the request of partners. CARE intends to fully scale-up community-based maternal and newborn care interventions from six to all nine divisions in phase II of the Child Survival program from 2000-2003.

Collaborating with partners can reduce duplication of effort and expand coverage of reproductive health interventions. CARE has recently initiated a Project Advisory Committee whose membership consists of the District Medical Officers, District Planning Officers, District Community Development workers, and a representative of HESAWA. The aim of the committee is to plan, review, and modify project progress and activities in order to strengthen the impact of the project, improve complementarity, and enhance the sustainability of the reproductive health program.

4 Technical Assistance Needs

During the fourth year of CBRHP, technical assistance is needed in the following areas:

a) Project evaluation design. In preparation for the final project evaluation and potential baseline for the extension, CBRHP plans to develop a participatory evaluation design by May 2000. Technical support from headquarters is needed to craft evaluation questions, and to identify data sources and tools. Additionally, the project plans to use verbal autopsy as a method to measure the impact of community interventions to reduce maternal and newborn mortality.

b) M&E Data quality review and Data Handling and Storage. During this year, the monitoring and evaluation plan was strengthened to review key information related to the project's implementation and effect. Given the large size of the project and number of communities and health facilities reporting, a streamlined system is needed to improve validity of data, reporting, and storage of data. CARE has developed software called MER, which may be appropriate for data management.

c) Perinatal Health Care Surveillance Site. Over the next few months, the project will work closely with the CDC to design and establish an active surveillance site in approximately 30 villages in the project area. The purpose of the surveillance system is to objectively identify primary causes of perinatal mortality and respond with targeted interventions. This is funded through the Woodruff Foundation for 22 months from November 1999 through August 2001.

d) Emergency Transportation Systems. Documentation, participatory monitoring and evaluation, and dissemination of successful models with the Centers for Disease Control and Prevention. This is funded through the Woodruff Foundation for 22 months from November 1999 through August 2001. See Section 7 for further information on this initiative. Many communities have identified a sturdy tricycle as the most appropriate means of transport; however, CARE Tanzania is seeking assistance from its counterparts in Bangladesh on the design and maintenance of these vehicles so that they can be successfully manufactured and repaired locally.

5 Substantial Changes in Program Description and DIP

a) Project Objectives

Given recent changes in best practices in the field of reproductive and child health, a need to strategically focus objectives and activities, and the specific recommendation made from the midterm evaluation team, the project staff and partners undertook an extensive review of its design and developed a revised, project Logframe.

This logframe includes modifications in the project objectives and targets and is presented in the table below.

These changes were discussed and documented with the Chief of the USAID/BHR/PVC Child Survival Program in June 1999 in Washington, DC.

code	Statement	Indicator	Means of verification
	Goal: To reduce maternal and neonatal morbidity and mortality in Kwimba & Missungwi Districts by the year 2000 in line with the national MOH goal of reducing maternal and neonatal mortality by 50% by the year 2000.	Maternal mortality rate Neonatal mortality rate Syphilis prevalence among antenatal clients	Not directly measured by the project because of complexity and requirement of large sample size
	OUTCOMES		
1	Increase the utilization of supervised maternal health services	Proportion of deliveries attended by trained professional	Baseline and endline KPC
		Proportion of WRA sought at least two prenatal consultations	MTUHA (quarterly) Maternal registry (daily) Observation (periodic)
		Proportion of mothers who receive 2 or more tetanus toxoid vaccines	Baseline and endline KPC
		Proportion of women who receive iron folate during pregnancy	MTUHA (quarterly) Observation (periodic) Community report (monthly)
2	Increase the appropriate utilization of emergency obstetric services for maternal and perinatal complications.	Met need for obstetric complications	MTUHA (quarterly)
3	Increase voluntary utilization of effective family planning methods	Proportion of women with children under 23 months who do not desire another child within the next two years who are using a modern contraceptive method	Baseline and endline KPC Observation (periodic)
		Couple years protection	Community report (monthly) MTUHA (quarterly)
4	Increase utilization of sexually transmitted infection control and prevention measures	Percent increase in number of clients receiving	Baseline and endline KPC Observation/mini-surveys (annually)
		Increase the percentage of mothers who can recognize at least 2 signs or symptoms of STDs from 11% to 20%	Baseline and endline KPC Observation/mini-surveys (annually)
		Increase the proportion of health facility staff able to effectively counsel patients on STDs to 20%	Facility assessment Facility report (quarterly) Observation (periodic)

code	Statement	Indicator	Means of verification
OUTPUTS			
1.1	Increased proportion of households with birth plans in place	Proportion of pregnant women with a household birth plan	Community report (monthly) Maternal registry Observation (periodic)
1.2	Increased availability trained VHWs and TBAs at the community-level	Number of villages with at least one of each of the following: - VHW who tracks at least 25% of expected pregnancies; -trained TBA who has conducted 6 or more deliveries in past 3 months	Community report (monthly) Observation (periodic)
1.3	Increased availability of skilled health providers in antenatal care, life saving skills/safe delivery and post partum care	Number of skilled providers at each type of health facility	Facility needs assessment Facility report (quarterly) Observation (periodic)
1.4	Increased availability of postpartum care at the community-level	Proportion of community-based deliveries receive postpartum care from VHWs/TBAs within first 24 hours	Community report (monthly) Maternal registry (daily) Observation (periodic) Endline KPC survey
1.5	Increased availability to iron folate supplements for pregnant women	Proportion of facilities and communities with no stock out of iron folate in past 30 days	Community report (monthly) Facility report (quarterly) Observation (periodic)
2.1	Increased number of villages with emergency transportation plan for obstetric emergencies	Number of villages implementing transport plan Number of villages with functional transport system	Community report (monthly) Field Officer report (mo) Observation (periodic)
2.2	Increased access of the population to basic emergency obstetric care services	Number of health centers providing basic EOC services	Facility assessment (baseline and endline) Observation (periodic) MTUHA (quarterly)
2.3	Increased awareness of maternal and newborn danger	Proportion of adults able to identify 2 or more danger signs	Baseline and endline KPC Observation/mini-surveys (annually)
3.1	Increased access to contraceptive methods available at community-level	Proportion increase of condoms distributed from baseline month distributed	Community report (monthly) Observation (periodic)
3.2	Increased availability of family planning education and counseling at the community-level	Number people reached through quality family planning information and education Proportion of couples receiving post partum family planning counseling	Observation (periodic) Community report (monthly)
3.3	Improved basic family planning services available at health facilities by skilled providers	Number of health facilities with skilled providers for basic family planning	Facility assessment Facility report (quarterly) Observation (periodic)

code	Statement	Indicator	Means of verification
4.1	Increased availability of information, education, and communication regarding STDs including modes of transmission, signs and symptoms, and preventive measures	Number of people reached through quality health education on STDs	Community report (monthly) Observation (periodic)
4.2	Increased health facility capacity to provide STD treatment and counseling services	Number of health facilities with skilled providers for syndromic management and confidential counseling	Facility assessment Facility report (quarterly) Observation (periodic)
4.3	Increased availability of protective measures from STDs/HIV at the community-level	Proportion of communities that have a condom distribution point with no stock outs in past 30 days	Community report (monthly) Observation (periodic)

b) Financial Status

Financial expenditures are in-line with the project agreement with the exception of the line item of consultants. A large amount of $135,662 was budgeted for consultants with the expectation that CARE would pay partner organizations to conduct project related training and provide additional technical assistance. Given in-country practices this was not necessary and collaborating partners were paid per diem and transportation costs rather than a contracting fee. Hence, expenditure on travel and per diems is slightly higher than originally awarded and contractual fees are lower.

Over the first year, the organization has more the met its match of 25% of total project costs. To date, CARE's match from three foundations, including a significant contribution from the Woodruff Foundation, and CARE-USA have totaled more than $450,000 representing a match of 35% of total funds.

6 Progress on implementing mid-term evaluation recommendations

Recommendation #1: Assess mechanisms to further enhance linkages between the project and the major partner, MOH, and other partners institutions operating in the project area. These include UMATI in family planning, AMREF in STIs, and HESAWA in village health workers. It is anticipated that these linkages when strengthened will complement project activities towards the achievement of the end of the project goals.

Over the past year, a great amount of effort has been devoted to improving collaboration and coordination with key counterparts and partners. This has included regular sharing

meetings have been held with AMREF, HESAWA, and the Ministry of Health at the national, regional, and district levels. This has resulted in better coordination of activities and sharing of resources and materials. Examples of these improvements include contribution to a draft national curriculum for Emergency Obstetric Care, joint participatory assessment of household risks related to health, and MCH/STI training for selected field staff.

Collaboration with UMATI has been limited to the sharing of IEC materials and research findings. Field implementation has been limited as they are not currently in Kwimba and Missungwi districts. CBRHP and UMATI continue to meet periodically to explore further areas for collaboration, including basic family planning training and community level assessments.

New partnerships have also developed with UNICEF at the national and regional levels, particularly in the area of safe motherhood. Another recent partnership has formed with Population Services International to strengthen social marketing of condoms and exploration of channels for insecticide treated bednets.

A formal Project Advisory Committee has been formed including counterparts from both District Health Management Teams, District Planning Officers, and selected Community Development Officers. The role of the committee is the review progress, link resources, and make recommendations to improve impact of program. The committee convenes quarterly to review implementation plans, monitoring data and overall progress.

Recommendation #2: Given the large geographic area and limited number of project staff, the project needs to explore appropriate avenues with the MOH and other partners on how to best cover all nine divisions of the project's intervention area.

Following the midterm evaluation, a follow-up/action planning workshop was held with representatives of the District Health Management Teams and CARE project staff. During this planning, several options were reviewed for improving coverage of the entire project area with targeted interventions. Options considered included seconding local health personnel, hiring more staff, fundraising, decentralization of staff, phasing staff from on geographic area to a next, working through partners, and targeting vulnerable communities and groups.

Although a preferred sustaining method for extending coverage would be through the secondment of local health personnel to the project, both districts are experiencing an acute shortage of staff. A long to medium term solution is to seek additional funding sources for increasing staffing and resources for community-level training.

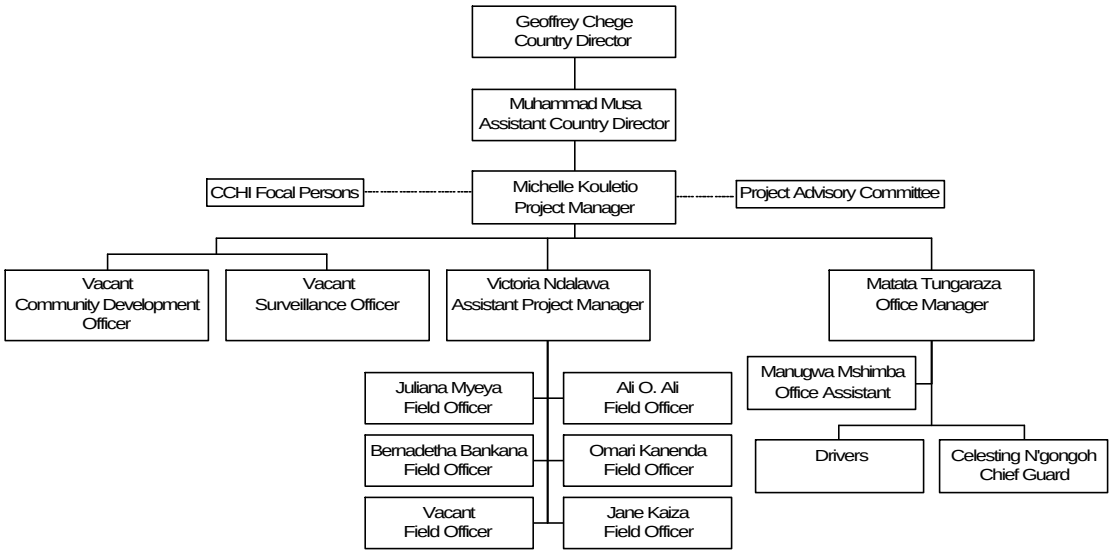
Given existing resources at the time, the most appropriate response was to decentralize the six project field officers from the project office to re-locate to specific geographic areas within the project. This was done in order to reduce travel time, reduce fuel consumption, and increase coverage capacity of the existing field staff. Job descriptions

were revised to include community mobilization, in-service training and technical support, data collection, analysis, validation and reporting. Further, given that positions were previously based on a vertical technical specialization, each field officer's training needs had to be assessed in order to identify individual gaps in technical skills in family planning, STIs, and maternal health.

To date, the project is active at the health facility level in all nine divisions. CARE project staff are based in six of the nine divisions working to improve the quality of interventions at the community level. At this point in time, it is recommended that CARE not attempt to cover the remaining three divisions directly. Instead, the project is working through its partners, the UNICEF CSPD project and the Roman Catholic Archdiocese village health worker program to expand coverage of interventions to all communities of the two districts. CARE will continue to provide assistance to these organizations in training and sharing lessons learned. CARE has proposed that it cover the remaining divisions through a follow-up grant proposal to be submitted to USAID BHR/PVC in December 1999 for FY 2000-FY 2003 funding.

A recent award from the Woodruff Foundation to continue collaboration between CARE and the CDC will enhance staffing at the middle management level. These Program Officers will be responsible to strengthen coordination with partners working in health and development in the project area to further improve the quality of reproductive health programming in the three divisions without CARE project field officers.

Community Based Reproductive Health Project Organization Chart (10/99)

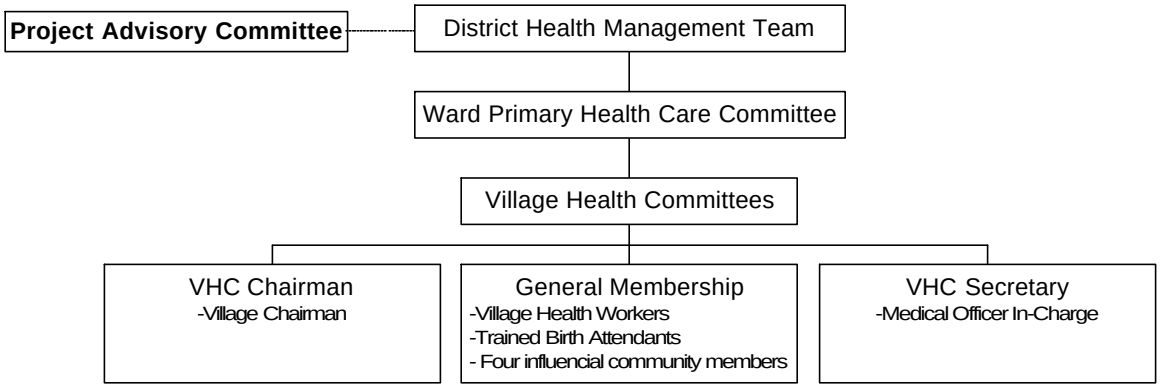


Recommendation #3: That the project, in an effort to breach the supervision gap for community level health providers, should facilitate strengthening the role of MOH, district officials, and community leaders to provide

supportive and participatory supervision for VHWs and TBAs. The Village Health Committees should be strengthened to fill this role.

The supervision structure promoted by the MOH and CARE attempts to emphasize local and sustained supervision of VHWs and TBAs. In this model, the village chairman is to serve as the principle supervisor, while the in-charge of the nearest health facility is to provide technical support and growth opportunities. This structure falls under the vision of a Village Health Committee, chaired by the Village Chairman with the health facility in-charge serving as the Secretary, membership includes community health volunteers and other influential and relevant community members.

Community Health Management Structures



In an effort to strengthen this supervisory model, CARE has been leading efforts to promote an incentives program where Village Chairman have access to resources to motivate active Village Health Workers. (See recommendation #8). Through this system, the supervisory role of the leaders is legitimized as compensation can be linked to performance. Hence the VHWs become accountable to the community leaders. From January through July 1999, a master team of community mobilization experts used participatory approaches in 32 villages to develop supervisory models for local leaders and health facility in-charges.

Field Officers continue to sensitize all community chairmen and MOH staff to the function, roles and membership of the Village Health Committee (VHC). Some have become quite active while others are showing limited interest. Several communities are integrating the function of the VHC into the general Village Committee agenda.

Finally, the project continues to hold periodic ward-level meetings for Village Chairmen, VHWs and TBAs for refresher training and to reassert the roles and responsibilities of community leaders in the supervision of volunteers, review of reports, and monitoring of bicycle and first aid kits.

Recommendation #4: Given the long term communication barriers in Kwimba district, the project receives immediate support from the country office to improve it's communication systems (telephone and fax) at the field office in order to be able to communicate in an adequate and timely manner.

Project management conducted an inventory of communication options and the country office increased pressure on the national telecommunications company to improve reliability of the telephone line. Communication options include using the neighboring post office line, purchasing a satellite phone, using local bus as courier, and better coordination of visits to the Mwanza sub-office.

Over the past 12 months, service disruptions have decreased due in part to the Country Office efforts to follow-up during outages with the national telecommunications company. Internet communications are not currently possible due to the poor quality of the phone lines. However, it has been announce that cellular phone service will be available in the district shortly and that new telephone lines are expected within the next two years. In the medium term, it is envisioned that communication options will improve. Until then, given the high cost of satellite communications, CBRHP will continue to capitalize on low technology options including the post office, local buses, and well coordinated trips to the Mwanza sub-office.

Recommendation #5: The project needs to broaden its IEC strategy and referral systems to improve male participation in reproductive health issues. This should be done with partners with documented experience in their respective areas of expertise.

A literature review of male involvement conducted both internationally and in Tanzania was conducted in early 1999. At that time UMATI shared important findings on gender communication about sexuality.

Through the initiative of project field staff, a series of focus group discussions and observation techniques were used in an applied research to study of how men and women communicate about household issues and their reproductive health behavior. Findings from this study have been compiled and are expected to be presented at the American Public Health Association meeting in November 1999 in Chicago. A copy of the paper to be presented is available upon request.

These findings confirm the need for targeted channels and messages to be designed specifically for men. This has been incorporated into most of the project's IEC activities including birth planning, post partum family planning education, and STI awareness. Further work in this area will include testing and modifying approaches to improve couple communication for health.

Recommendation #6: That the project modifies its IEC strategy further to capitalize on local channels of message transmission (e.g. local fairs, festivals, and market days). These efforts should result in desired behavior change among beneficiaries and further those indicators of message effectiveness are fine-tuned.

During the year, most of the IEC activities have been targeted at the household level as the project works with pregnant women and their families on birth preparedness and broader reproductive health issues. In addition, community dialogues are held to discuss issues around HIV/AIDS, family planning and emergency transportation preparedness.

Attempts to raise awareness about reproductive health during market days has proven ineffective. A trial was set-up in the Ngudu market from November 1998 - January 1999. During this time, the project learned that people are too busy with market related activities to participate in IEC activities and that no acceptable venue and little shade is available to protect the few spectators who did attend and participate. The project staff decided to look for other mechanisms such as post church services, health fairs, and festivals to disseminate broader reproductive health messages.

Recommendation #7: That the project reviews the current project information system in collaboration with the MOH to collect, analyze, and report on community-level activities and events as they pertain to project objectives and those of the key partner (MOH).

Over the past year, much progress has been made to review and tighten the project health management information system. This system links primary data from health facilities and communities to provide key monitoring data on antenatal care attendance and quality, pregnancy outcomes, place of delivery, couple years of protection, STI cases managed, and condoms sold. Findings are reported and acted upon on a quarterly basis. A complete monitoring and evaluation plan is available upon request. Under the follow-on grant CARE has proposed that project M&E efforts be more integrated into a strengthened MOH H/MIS, MTHUA for the two project dsitricts.

Recommendation #8: The project needs to advocate local government officials' establishment and ownership of an accepted, functioning, and sustainable village health worker incentives program.

In January 1999, a key workshop included regional and district MOH, HESAWA, and select community leaders resulted in a plan for delivering a regular VHW incentives system. As discussed earlier in this report on page 5, this package included a monthly payment of 10,000 Tsh (or 12 USD) for each village to be paid by the Ward Development Committee to be shared by all active VHWs.

Both District Councils passed this agenda by June 1999. Implementation of this by-law has been stronger in some wards than others. According to project staff estimates,

nearly 20% of all VHWs are receiving some form of payment. While a token payment is a good form of incentive, the project is promoting other types of motivation to VHWs including recognition for performance, social support, and increased social status.

Recommendation #9: In order to ensure that different MOH cadres of staff receive the correct quality and quantity of skill enhancement and knowledge, the project needs to target specific cadres of staff for training activities.

Since the midterm evaluation, key training events have included TOT for Community Mobilization and TOT for Emergency Obstetric Care. The Training of Trainers (TOT) methodology was used to better target training activities to personnel at different professional and language levels.

For each event, participants were carefully selected in collaboration with the District Health Management Teams. For example, TOTs for community mobilization included both health personnel and District Community Development Officers. The Emergency Obstetric Care training of trainers targeted personnel from hospitals that manage obstetric complications including theatre-in-charges, maternity ward in-charges, and nurse-matrons. The subsequent EOC training for health centers targeted medical officers in-charge and nurse-midwives, followed by in-service support for the rest of the health center staff.

Recommendation #10: In order to enhance staff's capacity to meet project objectives through capacity building of MOH personnel and VHWs/TBAs, the project needs to review current staff knowledge and skills to define areas of staff training needs.

As discussed under recommendation #2, the project field staff capacities in all three technical interventions were assessed and training plans developed. The areas of weakness included community participation, sexually transmitted infections, and obstetric complications.

Since these individual assessments, staff have been trained in participatory methods, facilitation skills, syndromic management of STIs (by AMREF), and emergency obstetric care. Some of the field officers were trained as trainers in these areas.
Other on the job training conducted this year for project staff includes research design; data collection, monitoring and analysis; computing; and principles of adult learning. This training has been accomplished through a combination of on-the-job training and experience, in-service supervision and coaching, guest trainers, and external training events.

Recommendation #11: In view that the community level interventions are increasing demand for services, the project and the MOH need to explore

opportunities and alternatives to obtain proper supplies and equipment at the health facility level.

Given the political environment, the introduction of fees for services to support increasing costs for drugs and supplies is a difficult policy to change. While all hospitals have introduced capitalization from fees for services, this practice has yet to extend downwards to the health center and dispensary levels. The policy that all pregnant women and children under five are to be treated free of charge remains as an important barrier to the ability of health facilities to generate enough income to cover the expenses from these exempted groups.

UNICEF has recently donated significant quantities of maternal care supplies and equipment, including delivery beds, blood pressure cuffs, and a variety of scissors and forceps. However, more equipment and supplies are needed to meet the demand of the population.

CARE is committed to assisting the District Health Management Teams to meet the minimum equipment and supply needs of the population. CARE's commitment has included identifying potential sources of support to the districts, pursuing potential future proposals for direct financial support, and advocating for cost sharing.

Recommendation #12: Through a revision of lessons learned, the project needs to develop a project extension proposal that will enhance or broaden the current scope of project interventions, or explore other new areas or components such as traditional child survival interventions.

A recent participatory assessment to identify leading health problems affecting household livelihood security indicated that malaria, maternal complications, diarrhea, ARI, and malnutrition are leading community priorities. These findings coincide with DHS and MOH statistics that indicate malaria, diarrhea, ARI as leading causes of under-five death. Collaborating partners' work in nutrition, hygiene, diarrhea control and prevention, ARI, and STIs.

From this assessment and meetings with partners and other stakeholders, CARE is in process of developing an extension proposal to include malaria and strengthened maternal and newborn care in the existing project area. These interventions will be targeted at reducing fetal-infant and under-five mortality using existing community structures and strong partnership with the Ministry of Health.

Recommendation #13: In light of recent advancements in identifying best practices in maternal and neonatal health programming, the project design should be reviewed and modified *as appropriate with technical leadership from CARE headquarters.*

As reported earlier, the project log-frame has been modified based on a technical review. A CARE USA consultant facilitated this participatory process in March 1999. by

reviewing project activities, objectives, and field work. During the technical review, the quality of reproductive health clinical services and the extent to which quality influenced utilization of these services by households were assessed. Major findings included:

- Informal costs, confidentiality, and respect are primary barriers to service utilization by households for delivery, family planning and STIs;
- Men are motivated to learn more about reproductive health and blame projects for not discussing issues with them;
- There is a very large gap between provider skill levels and service availability between the health centers and dispensaries. It would be very difficult in the short-term to upgrade dispensaries to basic EOC standards; and,
- Communities are interested in mechanisms to increase control over the quality of services provided by the facilities that serve them.

Recommendations from Technical Review of Project

Recommendations from the quality and service utilization assessment included the following:

Recommendation A: Decentralization/Supervision: Define the project area in terms of health centers with their catchment villages and dispensaries then attach project field officers to each of these "units". They should provide on the job training, supervision, quality assurance, and mobilization at the community, dispensary, and health center levels.

⌦ **Response A***:* Health centers are not evenly distributed across the nine divisions of the project area, making this an unrealistic/unfeasible recommendation. However, efforts are being made to strengthen the networks of dispensaries with their health center through collaboration with the district health management team and the field officer assigned to the division in which health centers are situated. Linkages have already been made between the health facilities and their catchment areas.

Recommendation B: Training Strategies for Health Facility Staff:

- As much as possible, training should take place practically, on the job, and/or through effective supervision which reviews and models appropriate practice.

- EOC training for health center staff should include refresher training on management of peri-natal complications, use of MVA equipment, and development of quality indicators for maternal health which can be incorporated into a continuous quality assurance process.

- Provide refresher training for staff from all dispensaries to cover FP side effects and counseling and per-natal danger signs for referral.

- Advocate for and assist partner organizations in the training of community cadres in key reproductive health messages and activities.

⌦ **Response B:** The project team fully agrees with this recommendation.

Recommendation C: Quality of Care: Field officers should work with their respective health centers to establish a regular process for quality review, problem identification, and problem solving. While this might follow a "COPE" format, the project time frame is limited and there are higher priorities than following the full COPE training process. The EOC training could assist with the identification of some maternal health service indicators to feed into this process, as might some of the community activities.

⌦ **Response C:** While we agree that quality of care is important, time and resources are a significant constraint. A serious attempt will be made in the identification and monitoring of a few quality indicators, e.g. met obstetric need and proportion of eligible antenatal clients receiving tetanus toxoid . The extension project should build on this recommendation for quality assurance.

Recommendation D: Community Strategy: Develop a community mobilization strategy involving existing structures such as PHC committees, Ward Development Committees (WDCs), and women's groups to address issues such as informal costs for health services, health center maintenance, and input into assuring quality of care. In the first 100 villages, the health workers will make up a key part of this strategy while collaborating with community workers trained by partner organizations is key in the remaining 78.

⌦ **Response D:** Efforts in the community continue and include strategies to address issues of access to quality and affordable health services.

Recommendation E: IEC Strategy: The project needs to tighten up its IEC strategy by defining fewer, clearly defined messages that contribute directly to achieving the project objectives and by outlining specific strategies for their dissemination to different target groups - particularly women of reproductive age and their husbands.

⌦ **Response E:** The project staff fully agrees with this recommendation and preliminary steps towards the development of a behavior change strategy are currently underway. The messages presented in the box below have been developed with project field staff and pre-tested with both men and women of reproductive age.

Key messages to remember from the Community-based Reproductive Health Team

1. All pregnancies are special and should be treated with care. Wise couples make provisions for the safe delivery of their newborn.
2. Danger signs for complicated pregnancies requiring immediate medical attention include antenatal bleeding, heavy post-partum bleeding, fever with headache, swelling of the face, hands and feet, and convulsions.
3. Health center and hospital staff are well-trained and provide the best services for complicated pregnancies. If you see a danger sign, give immediate assistance to transporting the woman to the health facility. This is a life that you can help save!
4. After giving birth is an ideal time to begin speaking with your partner about family planning. Space your children by at least two years to improve their chance for survival and your family's well-beings.
5. Unprotected sex can put you at risk of a sexually transmitted disease, infertility, or even HIV/AIDS. Please take care to protect yourself and your partner by using a condom.

Recommendation F: EOC Services: The five health centers in the project area should be upgraded to provide basic EOC services. The project and the DMOs will have to address issues in training, supervision, quality assurance, informal costs, and the need for IV solutions at the health center level to achieve this.

⌦ **Response F:** The upgrading of health centers to improve maternal care services is a key strategy of the project. IV solutions are not currently available in the essential drug program kit for health centers; however, the District Health Management Team can procure them from the medical supplies store. Efforts are being made to pilot test implementation of cost-recovery mechanisms for EOC services in order to improve the availability of supplies and equipment and increase community ownership of the facilities at Missungwi Health Center.

Recommendation G: Family Planning: The project should place most of its emphasis on improving the quality of basic family planning services (e.g. condoms, pills, and Depo Provera) at the dispensary level. These services should be linked with educational outreach via the IEC component through VHWs and partner networks. There is very little demand for IUD insertions. The inclusion of CBD roles for VHWs should be considered for the extension project.

⌦ **Response G:** Placing emphasis on quality family planning services at the

peripheral level facilities is appropriate. At the same time, we will have to strengthen links with VHWs postpartum family planning referrals.

Recommendation H: STI Prevention and Treatment: While in a good position to address knowledge about STI prevention and recognition at the community level, the project should not devote time and resources to training clinical staff in syndromic management as AMREF is already providing this assistance. The project should continue with condom promotion and distribution at the community level.

⌦ **Response H:** Given the size of the project area, time remaining, resources available, and partner activities, we agree that our activities should focus on sensitization and ensuring access to protective methods.

Additional support includes CBRHP's active membership on CARE's Global Maternal Health Team. Participation has resulted in updates on best practices, learning from other maternal health projects, cross-visit to CARE Bangladesh's Safe Mother Project, and better monitoring and documentation of CBRHP's work.

7 Work of Interest to the Broader Development Community

Over the past three years, the implementation of the Community-Based Reproductive Health Project has produced a number of important experiences and lessons learned that may be of interest to the wider development community. Some of these topics include community mobilization for emergency transportation, upgrading health centers to emergency obstetric care standards, and working with household members for birth planning. In this section, the work in emergency transportation systems development is highlighted.

Applying Principles of Community Participation for Emergency Transportation

CARE and the Centers for Disease Control and Prevention (CDC) have collaborated to develop a participatory approach to work with communities to identify, implement, monitor and evaluate an emergency transportation plan. The aim of the strategy to increase community participation in identification of transport options and realistic action plans combined with CARE support for learning from other models and problem solving is expected to lead to more appropriate and sustainable transport systems than other approaches.

Six-Step Approach for Community Transport System Development

1) Training of master trainers for community mobilization: Trained a selected group of 10 local community development professionals, CARE staff, MOH staff, and government leaders on community participation and mobilization concepts

2) Master trainers facilitate a one-day community mobilization exercise with leaders, influential people, and village health workers to develop initial options

3) Community leaders conduct community meetings to agree upon an action plan to improve transportation during health emergencies

4) Master trainers attend follow-up meeting to review community action plans, discuss questions raised by the community, and finalize the action plan

5) Communities implement action plans (saving money, developing systems, and finding suppliers) with support from CARE field staff

6) Project reviews progress, highlights and disseminates successful models, conducts research and development on tricycle production

To date 22 of an initial 32 most isolated villages have plans in place. Of these communities, more than half (n=12) have actively begun contributing funds to the plan, and 5 have functional systems.

Using a community-focused approach and the diversity of community settings, a variety of transportation systems have been identified to suit the different geographic settings and barriers of each of the communities. For example: Communities located on the lake have selected canoes, identified rowers, set prices, or even raised funds for a motor engine.

Communities residing with passable roads have opted to try the tricycle to increase speed to the hospital. Communities residing on roads heavily used by trucks, a savings fund has been identified to improve ability of households to pay driver for transportation.

Lessons learned about facilitating factors for successful transportation planning are:

1) communities with strongest interest in health or with recent experience maternal complications are the most likely to have some type of plan in place;
2) communities furthest away from a health facility are more likely to identify with the need to have a transportation system; and
3) communities with prior history of actively implementing plans more likely to have a transportation and supervision plan.

Lessons learned about constraints to transportation planning include:

1) many communities have a strong external dependence;
2) non-supportive community leadership is an indicator of social cohesion;
3) there is an appropriate technology limitation of feasible transport options;
4) there are competing demands for scarce community resources;
5) fatalistic attitudes about maternal survival;
6) need to balance community demand with supply of improved quality of services;
7) community mobilization for transportation is a long process pressured by project timeframe; and
8) traditional community leadership restricts women's participation.

For those interested in replicating this approach, CBRHP recommends:

- Carify the purpose of the exercise among project staff. Is the ultimate goal to foster community empowerment or to have transportation systems?
- Assess extent of community cohesion in advance to determine appropriate approach and level of effort.
- Facilitate communities' own development of action plans, including timetable and responsible persons to achieve appropriate and sustainable transport systems.
- Seek means to ensure women are involved in selection of transportation options, as they are not necessarily participants of the community leadership.
- Expect an extensive effort by CARE and its partners to result in better implementation of the community plan.
- Identify viable models from the beginning to maintain community's trust and confidence.